DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 - 0 1 0

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250FACILITY

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $(567,373)
b. FFY 2005 $((2,269,492)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-C, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-C, page 1

10. SUBJECT OF AMENDMENT:
NURSING FACILLITY SERVICES – PAYMENT FOR RESERVED BEDS

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED: August 24, 2004

16. RETURN TO:
Department of Community Health
Medical Assistance Plans
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 26, 2004

18. DATE APPROVED: October 12, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Hugh L. Webster for Renard Murray

21. TYPED NAME: Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

PAYMENT FOR RESERVED BEDS

Regular state payment is permitted for reserving beds during a recipient's absence from an inpatient facility with the following limitations:

1. The patient's plan of care provides for absences, other than hospitalization.

2. Seven (7) days per hospitalization for Medicaid patients who are hospitalized during a stay in the nursing home.

3. Planned therapeutic home visits.

    - For nursing facility residents up to eight (8) days in any calendar year with no limit on the number of days per visit

    - For ICF-MR residents up to thirty (30) days per calendar year with no limit on the number of days per visit

Payments for reserved beds are made at 75% of the rate paid for days when a patient is onsite at a facility. Because payments for reserved beds are not subject to the nursing home provider fee, the payment rate for reserved beds excludes any compensation for the provider fee.